CONSUMER CHOICE

ANSWERS TO FREQUENTLY ASKED QUESTIONS ABOUT THE GEORGIA CONSUMER CHOICE OPTION

Q: What is the Consumer Choice Option?

A: It's a Georgia state law that became effective January 1, 2000. It allows you to receive covered services from providers, hospitals and ancillary care providers outside your health plan's provider network.

- You must apply for this option by enrolling in the Consumer Choice Option program.
- You must nominate a provider as your "Consumer Choice Provider."
- The provider you nominate must agree to participate in the program and to comply with your health plan's processes.
- You can only enroll in the Consumer Choice Option program during your employer's open enrollment period.

Q: Can I nominate more than one provider?

A: Yes. But it's best to nominate only the providers you intend to see regularly for care.

Q: Can I nominate any physician?

A: Yes, as long as he or she is a licensed physician located in the state of Georgia and does not participate in a CIGNA HealthCare network. If the physician you nominate does not agree to participate in the Consumer Choice Option program, you cannot re-nominate that physician. And there's no need to nominate a physician who already participates in your CIGNA HealthCare plan.

Q: Is a "nominated" provider different from a "participating" provider?

A: Yes. A nominated provider is not a CIGNA HealthCare participating provider and does not become one through the Consumer Choice Option program.

Participating providers are contracted with CIGNA HealthCare and meet CIGNA HealthCare credentialing requirements and quality standards. Because a nominated provider is chosen from outside our network, he or she is not credentialed by CIGNA HealthCare and we can't make any assurances about the quality of care you'll receive from this provider.

Q: How do I nominate a provider? What's the process?

A: *Complete a Provider Nomination Form*. Your CIGNA HealthCare plan enrollment kit should contain a Provider Nomination Form like the sample featured in this guide. Make sure you provide all the information requested in the section "To be completed by CIGNA HealthCare participant." If you don't have a form, just ask your company's benefits manager.

Forward the form to the provider you're nominating. He or she provides all the information in the section "To be completed by nominated non-network provider" and mails or faxes the form to CIGNA HealthCare of Georgia at the address/fax number listed on the form.

We contact your nominated provider to outline the policies, procedures and compensation terms of your CIGNA HealthCare plan. According to the Consumer Choice Option law, your services will be covered only if the provider you nominate agrees to these terms.

We contact you in writing to notify you whether or not your physician agreed to the program terms.

Q: Are all providers accepted into the Consumer Choice Option program?

A: No. To be accepted, a physician you nominate must:

- Be fully licensed by the State of Georgia
- Physically located in the State of Georgia
- Not be a participating provider in the CIGNA HealthCare of Georgia provider network that serves your company's benefits plan.
- Accept CIGNA HealthCare provider terms

Q: After I make a nomination, how soon can I go to that provider for care?

A: It depends on how soon the physician submits your form and signs the final agreement. Once we receive all necessary information, we notify you in writing within three business days whether or not your provider has been accepted into the program. If accepted, you can go to the provider you've nominated as soon as you schedule an appointment! However if you enroll in a plan that requires a referral before receiving specialty care, you and your provider will need to follow CIGNA HealthCare of Georgia's referral process prior to the appointment.

Q: Does the nomination expire? Is it valid for a specific length of time?

A: No. You can see an accepted provider for care as long as you maintain your status as an eligible participant of a CIGNA HealthCare health plan.

Q: Is there a cost for me to enroll in the Consumer Choice Option program?

A: Yes. You'll likely experience an increase in your health benefits plan premium. When you enroll in Consumer Choice Option, your premium increases whether or not you receive care from a nominated provider. Contact your employer's benefits manager for more details.

Q: Do my benefits change?

A: No. Your benefits remain the same with or without the Consumer Choice Option. And you shouldn't need to file claim forms. Your accepted provider will file them directly with us.

CIGNA HealthCare

Provider Nomination Form for Consumer Choice Option
CIGNA HealthCare of Georgia, Inc. & Connecticut General Life Insurance Company

To be Completed by Patient

Patient's Name	Employee's ID Number (and Name, if different than patient)	Group Number, if applicable
Patient's Address (Street, City, State, Zip)	Patient's Date of Birth / /	
	Patient's Telephone Number ( )	Patient's Fax Number ( )

By signing below, the Patient verifies that they are enrolled in CIGNA HealthCare's Consumer Choice Option. The Patient further acknowledges that the nominated provider is not an in-network or participating provider with CIGNA HealthCare. This provider, therefore, has not been credentialed by CIGNA HealthCare and thus CIGNA HealthCare cannot make any representations as to the quality of care the Patient may receive. The Patient also understands that any and all physicians, hospitals and any others who are not in-network providers must be nominated by the Patient and accepted by CIGNA HealthCare prior to any service being performed by the provider in order for the service to be eligible for coverage under the Consumer Choice Option.

Patient's Signature (or legal representative's if Patient is a minor or incapacitated)	Date
_____	_____

To be Completed by Provider

Name of Nominated Provider	Name of Provider Group, if applicable	Provider's Georgia License Number	Provider Tax ID Number
Provider Address (Street, City, State, Zip)		Provider's Telephone Number ( )	Provider's Fax Number ( )
		Hospital(s) Where Provider Has Priveleges	

By signing below, the provider acknowledges that they are located within the State of Georgia and fully licensed by the State of Georgia. Provider also attests that he/she is not a CIGNA HealthCare participating provider and has not been credentialed by the plan.

Provider's Signature	Date
_____	_____

Nominated Provider: Please complete all of the above indicated information, sign and forward this form via mail or facsimile to: Consumer Choice Option, CIGNA HealthCare of Georgia, Inc., Two Securities Centre, 3500 Piedmont, Suite 200, Atlanta, GA 30305, fax number (404) 443-8998. Failure to complete all of the required information will result in disapproval of nomination. Upon receipt of the Provider Nomination Form, CIGNA HealthCare will contact the Provider's office to discuss the CIGNA HealthCare's Quality Management criteria and payment terms.

Provider: BY SIGNING BELOW YOU ARE AGREEING TO ACCEPT CIGNA HEALTHCARE'S PAYMENT TERMS ACCORDING TO CIGNA HEALTHCARE'S REIMBURSEMENT POLICIES. YOU ARE ALSO AGREEING TO COMPLY WITH CIGNA HEALTHCARE'S QUALITY MANAGEMENT CRITERIA. The criteria will include, but are not limited to: (i) pre-certification or prior approval of services; (ii) Patient eligibility at the time services are rendered; (iii) the services rendered qualifying as covered services under the patient's benefit plan; and (iv) any cost sharing provisions in the Patient's benefit plan. This form is not to be construed as a guarantee of payment. Provider hereby agrees to accept CIGNA HealthCare's payment terms and agrees not to balance bill the Patient. Provider additionally agrees to comply with CIGNA HealthCare's rules and provisions.

_____ _____

Provider's Signature Verifying Acceptance of these Terms Date

Please keep a copy of this completed form and mail/fax the original to CIGNA HealthCare at the address/fax above. A confirmation letter will be mailed or faxed to the Provider.

CCPROV94GA 5/2000

Provide all information requested in this portion of the form. Do not fill out any other areas-your provider completes the rest.

Make sure to sign and date the form.

Give the form to the provider(s) you're nominating. He or she is responsible for sending it to us.

The nominated provider signs here before submitting the form to us. Upon agreement of the program terms, the provider signs the form a second time.

Your provider must forward us the completed form for processing.